MDR: M4-04-4351-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/9/03.

I. DISPUTE

Whether there should be reimbursement for CPT code E0745, for date of service 8/9/03.

II. RATIONALE

The services in dispute were denied as, "F-Reduced according to Fee Guideline."

The Requestor states, on the Table of Disputed Services, "We feel that we are due our full billed amount for the equipment provided to this patient. The carrier has incorrectly reviewed this claim. These claim items were submitted based on the 1991 Fee Guidelines."

The Carriers response dated 1/28/04, states. "The Requestor failed to meet the coverage criteria for a Neuro-muscular stimulator as defined by both the Commission's and Medicare's guidelines."

Commission Rule 134.202 Medical Fee Guideline (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Section (c)(2)(A) states, "For Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E, J, K, and L: 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;" and Section (d) states, "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

The Medicare Fee Schedule lists reimbursement for HCPCS E0745 is:

$89.51 x 125% (conversion factor) = $111.89 (Maximum Allowable Reimbursement).

Reimbursement is recommended.

III. DECISION AND ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement in the amount of $111.89. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $111.89 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision, and Order are hereby issued this 31st day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division
TC/tc